Managers Influence on the Professional Practice Environment

DNP Final Project

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Abstract

Healthcare is challenged to reinvent itself to be quality driven, fiscally sound and evidence-based, while its workforce is aging and the population of baby-boomers needing care, is growing. A positive professional practice environment is vital to assure safety of patients and staff, improve professional staff recruitment and retention, and sustain an organization's financial viability. Managers are reported as the single greatest influence on the professional practice environment. The purpose of this project was to examine the perceived influence of nurse managers on the professional practice environment before and two months after a two-day leadership course. Although there were no statistically significant results, small effect sizes in three of the six subscales of the *Leaders Influences on the Professional Practice Scale* (*LIPPES*) suggest that: 1) the program participant's expectations of their clinical staff changed after exploring the future of healthcare, organizational climate and participative management styles; and 2) the course raised awareness of how leaders need to make a greater impact on the organization**.** The *LAPP* program contributes to developing nursing and healthcare leadership so that they better influence Professional Practice Environment (PPE).

Keywords: healthy work environment, professional practice environment, workplace culture, Nurse Friendly hospitals, Magnet hospitals, influence, nurse managers, nursing leadership, *LIPPES*.

Managers and their Influence on the Professional Practice Environment

Chapter One: Introduction

Healthcare is facing an ominous challenge to reinvent itself to be quality driven (IHI, 2014), fiscally sound (American Association of Colleges of Nursing, 2006) and evidence-based (Melnyk & Fineout-Overholt, 2011; Institute of Medicine, 2003), while its workforce is aging and the population of baby-boomers needing care, is growing (WHO, 2012). Positive Professional Practice Environments (PPE) are essential for nurses to perform well in this dynamic period of constant change. Negative PPEs lead to ineffective collaboration due to intimidating behavior between interdisciplinary team members (ISMP, 2013) and dangerous communication patterns (AHRQ, 2012). Negative PPEs struggle with low staff and patient satisfaction, safety issues, greater preventable errors, increased incivility (or lateral violence) with coworkers, and practices that are inflexible based on "we have always done it that way" (Suhonen, Stolt, Gustafsson, Katajisto, & Charalambous, 2013; Ulrich, Lavandero, Woods, & Early, 2014). There are many studies that have used a variety of interventions to facilitate positive PPE, however the common thread through all the interventions involves the influence of managers and leaders on the PPE (Bishop, 2013; Brunges & Foley-Brinza, 2014; Calarco (2011).

Background

The United States (U.S.) spends more per capita on health care than any other developed country in the world (World Health Statistics, 2013). Health care is approximately 17.2% of the Gross Domestic Product (NHE Fact Sheet, 2014). However, most alarming is the World Health Organization's Report that ranked the U.S. 37th in overall performance of 108 member states (WHO, 2013). Unfortunately, the U.S. has the highest healthcare costs with poor performance

outcomes. These outcomes were described in a series of Institute of Medicine reports, including: 1) “To Err is Human: Building A Safer Health System” (1999); 2) “Crossing the Quality Chasm” (2001); 3) “Keeping Patients Safe: Transforming the Work Environment of Nurses” (2003) and 4) “Patient Safety: Achieving a new Standard for Care” (Aspden, 2004). These reports were major contributors that propelled quality improvement and evidence-based practice initiatives in healthcare settings across the country. With these initiatives come many changes in the work of the nurse and a challenge to maintain competence.

The Institute for Healthcare Improvement (IHI) describes the Triple Aim Initiative (IHI, 2015) as a framework to optimizing health care system performance. The Triple Aim includes: 1) improving the patient experience in care, 2) improving the health of populations, and 3) reducing the per capita cost of health care (IHI, 2015).

To respond to this challenge of improving quality and patient experience while reducing costs, the U.S. healthcare environment is awash with technology (Burke, Menachemi & Brooks, 2005). Electronic medical records, alarms, smart IV pumps, electronic patient education and call light systems attached to staff tracers barrage the care providers as they use the technology to reduce errors and improve quality. In addition, patients have higher acuity, more complex care demands and are often emotionally so stressed from economic and life distress that they make the work of providing nursing care more difficult. McCauley (2005) called for creating healthy work environments for patient safety, staff retention and organization’s financial viability. Today, the Institute for Healthcare Improvement (IHI, 2015) expands upon this recommendation with key environmental characteristics that drive these healthcare innovations (i.e. unconditional teamwork; recognize and value everyone’s knowledge, experience, and input; inclusiveness and diversity; honesty and transparency; vision and agility; and taking time to celebrate successes).

The Problem

To accomplish the Triple Aim described above, the largest number of healthcare workers (nurses) will need a positive PPE to perform well in evolving and stressful situations. Nursing care is emotionally, mentally, spiritually and physically demanding. The work environment needs to be supportive in all of these aspects to recruit and retain the best and brightest caregivers. With these best and brightest nurses, the quality of care and patient experience will improve as the cost of care is reduced. This leads to several questions. How is a positive PPE created? What facilitates development and maintenance of a positive PPE?

Leaders are key to a strong PPE (Paquet, Courcy, Lavoie-Tremblay, Gagon and Maillet, 2013.) The communication styles, supportive and facilitative behaviors and the collaborative posture of nursing leadership are traits important to developing a PPE. Since managers and those in nursing leadership roles are pivotal in their influence of the PPE, this project focuses on developing the knowledge, skills and attitudes needed by leaders of nurses to create and sustain a positive PPE.

Project

The purpose of this program evaluation project was to determine the effects of a continuing education leadership development workshop entitled the *Leadership Academy for Peak Performance* on leaders' perceived influence on the professional practice environment This program evaluation project measured the leaders' reported influence over their PPE prior to and 2 months following completion of the educational program.

Significance

The significance of this proposed project to nursing and healthcare is that when the *Leadership Academy for Peak Performance (LAPP)* coursework develops nurse leaders to better

influence their professional practice environments, improved outcomes should be realized. The literature indicates that much of the knowledge, skills and attitudes required by nurse leaders are incorporated in the *LAPP* program, identifying it as an evidence-based curriculum. This project focused primarily on the first six of the Doctorate of Nursing Practice (DNP) Essentials:

I. Nursing Science and Theory: Scientific Underpinnings for Practice
II. Systems Thinking, Healthcare Organizations, and the Advanced Practice Nurse Leader
III. Clinical Scholarship and Evidence-Based Practice
IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
V. Healthcare Policy for Advocacy in Health Care
VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Nurse leaders need to use systems thinking and understandings of how healthcare organizations behave to influence the PPE. This project demonstrated the need for each leader to step back to see a more global picture. Leaders need to see how the areas that they influence will better function considering the changes in the larger organization (own institution), as well as the geopolitical environment (regional, governmental, insurance, etc.). With this broader understanding of the unit's place in the healthcare system, the leaders will influence the PPE. Effective leadership must now be both interdisciplinary and collaborative to accomplish the triple aim for healthcare. Measuring the participants perceived influence on the PPE prior to and following the educational offering is a quality indicator suggesting that the educational experience is having the intended effect.

The Project's PICO Questions

The PICO question that guided the development of the project was: *"In acute care settings (P) how does perception of a positive PPE (I) versus a perception of a negative PPE (C) affect nurse engagement, satisfaction and retention (O)?"* With further review of the literature, a narrower PICO question was asked: *"In nurse leaders (P), how does participating in an evidence-based curriculum for leader development (I) versus not participating (C), affect staff retention, staff satisfaction and quality of care (O)*?

Plan

This project was an educational program impact evaluation. The sample was drawn from the leaders of nurses who were participants of the Fall-2014 *Leadership Academy for Peak Performance* (*LAPP*). The *Leadership Influence over Professional Practice Environments Scale (LIPPES)* (Adams, Nikolaev, Erickson, Ditomassi & Jones, 2013) was administered before the course began. Two months after the course completion, the survey was re-administered. Analysis of the pre-survey and post-survey data captures the impact of the *LAPP* program as an intervention to strengthen the influence of nurse leaders in their PPE.

Chapter Two: Review of the Literature

Positive PPEs have lower staff turnover (Brunges & Foley-Brinza, 2014), lower absenteeism (Leiter, Laschinger, Day & Oore, 2011), fewer preventable errors (Kooker & Kamikawa, 2010), higher nurse satisfaction (Laschinger, Leiter, Day, Gilin-Oore & Mackinnon, 2012) and greater nurse engagement (Bishop, 2013). These outcomes reduce the costs of care and improve patient outcomes. Nurse Managers are reported as the single greatest influence on a positive PPE. To develop the knowledge, skills and attitudes essential for those facilitating the PPE of a clinical area, education must incorporate learning experiences for nurse leaders based on themes in the literature describing how leaders influence the work environment.

The Professional Practice Environment

Professional practice environments or healthy work environments (HWE) have become the focus of many safety, quality improvement, employee satisfaction and retention initiatives (Avey, Luthans, Smith & Palmer, 2010; Bartholomew, 2006; Buffington, Zwink, Fink, DeVine & Sanders, 2012; Casida & Parker, 2011; Clark, 2011; Duffield, Roche, Blay & Stasa, 2010; Hoebbel, Golaszewski, Swanson & Dorn 2012; Kramer, Maguire & Brewer, 2011; Lawrence, 2011; Manojlovich, 2005; Manojlovich, 2007; Rathert & May, 2007; Simmons, 2012; Laschinger, & Leiter, 2006).

The American Association of Critical Care Nurses (AACN) describes six standards for HWE: 1) skilled communication, 2) true collaboration, 3) effective decision making, 4) appropriate staffing, 5) meaningful recognition, and 6) authentic leadership (AACN, 2010).

Similar to the AACN standards, the American Organization of Nurse Executives (AONE) has principles and elements of a "healthful" work environment. These include: 1) collaborative practice, 2) communication rich, 3) culture of accountability, 4) adequate staffing, 5) competent,

credible visible leaders, 6) shared decision making, 7) encouraged professional growth, 8) recognized value of nursing's contributions, and 9) recognition by nurses for meaningful contributions to practice (AONE, 2004).

In Texas, the Nurse-Friendly (NF) Hospital Project identified 12 criteria for hospitals seeking to improve nurses' work environments. Criteria specific to positive PPE included: control of nursing practice, nurse recognition, balanced lifestyle, zero tolerance for nurse abuse and middle management accountability (Meraviglia, et al, 2008).

Nurses in Magnet® designated institutions, where employee satisfaction, engagement and retention are high, report greater autonomy over their professional practice environment and better communication amongst clinical disciplines and administration (Kramer et al., 2011). The Magnet Model components include transformational leadership, structural empowerment, exemplary professional practice, new knowledge, innovations and improvements and empirical outcomes. Many factors contribute to satisfaction, engagement and retention, so the professional practice environment should support all components to meet this variety of needs.

Kramer, Schmalenberg & Maguire (2010), completed a systematic analysis of publications leadership practices essential for a Magnet environment. Nine "environment-improving" recommendations resulted:

1) Quality of nurse leadership- visionary, visible, open, skilled communication.
2) Opportunities for education- tuition reimbursement, continuing education, certification.
3) Nurse staffing- adequate and flexible scheduling.
4) Flat, decentralized organizational structure- shared decision making.
5) Collaborative, interdisciplinary relationships

6) Culture of Interdisciplinary teamwork and safety

7) Salary and benefits competitive for geographical area

8) Quality improvement, research and evidence-based practice (EBP) initiatives.

9) Meaningful recognition- nurses' contributions, reward/pay for performance.

(Kramer, et al., 2010)

The common themes between AACN, AONE, Texas NF and Magnet® designated institutions are communication, collaboration, decision making and leadership. These themes were deemed the quality indicators to be further explored as measurements of a positive PPE.

Data supporting the need to focus on PPE. Individual hospitals routinely collect nurse retention, vacancy, intent to leave and employee and patient satisfaction data. Exit interviews, 360 degree performance appraisals, annual learning needs assessments, RN to BSN percentages, number of certified nurses and shared governance activities are additional means to gather data regarding the perception of the practice environment. Benchmarking with both internal and external data is useful to recognizing areas for improvement and making progress with PPE. The Agency for Healthcare Research and Quality (AHRQ) and Institute for Safe Medication Practices (ISMP) are two national survey data sources for comparison.

Agency for Healthcare Research and Quality (AHRQ). Evidence indicating the prevalence of work environment problems is found in the AHRQ survey of hospitals for safety culture indicators (AHRQ, 2012). The results from this survey reveal that only 47% of staff feel free to question those with more authority; 46% thought units did not coordinate well with each other; and 41% stated that things fall between cracks when transferring patients. These responses demonstrate dangerous communication patterns. When less than 50% of staff are comfortable

advocating for patient needs with authoritative figures and they believe that communication is not coordinated well, there are many occasions for errors to occur.

Institute for Safe Medication Practices (ISMP). Another data source supporting the need to focus on PPE, is the ISMP national survey (ISMP, 2013). The ISMP describes the occurrence of intimidation by physicians, prescribers, pharmacists, nurses and others. Results from this survey revealed that 61% felt that their organization did not deal effectively with intimidating behavior and 49% felt that past experiences have altered the way they clarify medication orders. These responses support that there is a need to improve communication and collaboration among the healthcare team in order to establish a positive PPE.

Manager Communication and Collaboration.

Porter-O'Grady & Malloch (2010) use the term "healing environment" to connote ideal healthcare systems. The authors describe how innovative leadership is needed to influence this environment through communication and collaboration. A healing environment responds to "…organizational factors (negative culture and climate, restrictive and authoritative organizational structures, poor leadership, incivility, workload stress) and professional issues (dissatisfaction with the work environment, poor interpersonal relationships, job satisfaction, role stress)" (p.268)."

Paquet and colleagues (2013) describe four perceptions of the psychosocial work environment largely mediated by nursing leadership: "apparent social support from supervisors, appreciation of workload demands, pride in being part of the team and the effort/reward balance" (Paquet et al., 2013, p 87). Communication and collaboration are the essence of interventions demonstrated by leadership that effect the psychosocial health of the work environment.

Nursing leaders can either facilitate or impede the PPE. For example, supportive leadership builds the emotional and spiritual "capital" of staff when they: 1) encourage staff to return to school for further development; 2) empower nurses to "make a difference" through unit practice changes, 3) guide nurses with morally and spiritually distressing situations; and 4) recognize nurses for advocacy and innovation at the bedside. Therefore, any quality improvement initiatives with an aim to improve the PPE should involve the communication and collaboration practices of the leadership (Hartung and Miller, 2013).

Interventional Study Outcomes to Improve PPE

Calarco (2011), DiMeglio et al., (2005), Hall, Doran & Pink (2008), Laschinger et al. (2012), and Leiter, Laschinger, Day & Oore (2011) used similar interventions to address their staff's PPE. In each instance, the staff was charged with a task and their interventions were supported by leadership. These group tasks included: 1) positive organizational scholarship or learned optimism (Calarco, 2011); 2) group cohesion and job enjoyment (DiMeglio et al., 2005); 3) change interventions for work environment (Hall et al., 2008); and 4) CREW process (Civility, Respect, Engagement in the Workplace) in both Laschinger et al., (2012), and Leiter et al., (2011). The unit staff concentrated for a 6-12 month period on the work environment initiatives and in all studies a pre and post survey was administered. The commonality in these studies was the requirement that the groups' leadership supported them with: 1) recognition for their work; 2) time off the unit to complete the work; 3) assistance with challenges; and 4) holding the individual and group accountable.

In Florida, Brunges and Foley-Brinza (2014) realized a culture change over a three-year period as a result of a combination of projects. The projects included: 1) safeguarding breaks; 2) making a serenity room; 3) creating the patient ambassador role; 4) holding people

accountable for bullying and unprofessional behavior; 5) designating a student mentee to work with staff members on culture change; 6) organizing fun events; 7) redesigning the unit; 8) lessening stress by adjusting schedules; 9) providing education activities; 10) launching a Unit Practice Council; and 11) improving reward and recognition. The outcomes included increased employee satisfaction and retention rates (Brunges and Foley-Brinza, 2014).

The Rickard and colleagues (2012) intervention involved assessing the nurses' activities by using a reported valid and reliable Workload Tool. Following this assessment, the leaders responded to the findings of the Workload Tool to improve the PPE. These were system level interventions including hiring approximately 25% more staff, supporting more staff through Graduate school, providing more Continuing Education offerings, and strategic recruitment. Unlike the other studies, this intervention did not include staff work groups designing changes to improve work environment. The changes were made by the leaders based on the Workload Tool. Through the actions of the leaders, the PPE was changed for the better.

Using a similar process of assessing the current practice, then using the responses to guide changes, Meraviglia, et al, (2009) implemented the 12 Nurse Friendly (NF) criteria in 30 hospitals as a means of creating a positive PPE. During the project, consultants recommended strategies to incorporate criteria into the practices of the organization. The Nursing Work Index-Revised (NWI-R) was used to assess the nurses' perception of NF criteria before the intervention and 9 months following the intervention. Some of the remarkable results included: 1) nurses with more education rated the environment positively; 2) nurses working at the hospital longer rated the Chief Nursing Officer competency higher; 3) nurses working at the hospital longer agreed that there was a Zero Tolerance policy for nurse abuse; 4) nurses who worked more hours per day were more critical of safety, how to address patient concerns, and nurse recognition; and

5) rural/small hospitals showed positive changes and improved nurse retention (Meraviglia, et al., 2009).

Bishop's (2013) intervention was providing a three day retreat focused on caring for self, colleagues and patients. Using the Utrecht Work Engagement Scale, participants were found to have statistically significant increases work engagement in areas of vigor (levels of energy, resilience, make effort); dedication (enthusiasm, pride in, inspired by job); and absorption (happily immersed in work) following the retreat. Nursing leaders who provide a supportive environment to reflect and share the meaning of caring influence the PPE positively (Bishop, 2013).

Cummings and colleagues (2013) implemented a province-wide (Alberta, Canada) Leadership Development Initiative (LDI), including an interactive 12 month process for 259 leaders. Just as the role of leaders in a dynamic healthcare system is complex, the LDI program was involved and, therefore, challenging for participants to complete with earnest engagement in all the learning activities. Evaluation of the program was through surveys and interviews of participants as well as anecdotal observations by team members noticing changes in participants' leading behaviors. Though participants reported that the evaluation was too early to see the influence of the leadership practices on the work environment, some improvements were noted including "leading self"- how leaders reflect on their own skills and practice (Cummings, et al., 2013).

Kooker and Kamikawa (2010) intervened to build a Magnet culture on their journey to designation. Through the "Building Capacity to Improve Patient and Nurse Outcomes" training grant funded by Health Resources and Services Administration, multiple objectives were established. These objectives focused on areas of greatest need for improvement including new

graduate nurse retention, registered nurse satisfaction and decubitus ulcer rates. The organization implemented a 1) New Nurse Fellowship Program extending through a year; 2) Clinical Coaches role to be supportive as preceptors; and 3) Nurse Manager Academy focused on communication, recognition and accountability in the unit culture (Kooker & Kamikawa, 2010). Their outcomes were increased nurse retention rates (began at 55.97, ended 68.2) vacancy rate decrease (began 11.26, ended 2.19), patient satisfaction increase (began 84, ended 87.8) nurse satisfaction increase (began 41, ended 48) and decubitus ulcer rate decrease (began 15.3, ended 6.7).

The last interventional study was an evaluation of a two-month, 40 hour program called UPMC Leadership Development for Nursing Middle Managers (Fennimore and Wolf, 2011). The participants reported improvement in all competency areas on the Nurse Manager Inventory Tool over a six-month period. This program described Nurse Managers as "chief culture builders" (Fennimore and Wolf, 2011, p 204). The remarkable outcomes of this program implemented repeatedly over a two-year period included nurse turnover rate improvement and participant self-reported application of concepts in the daily work (Fennimore and Wolf, 2011).

All 12 of the interventional studies on improving the PPE, unit culture or work environment demonstrated a combination of outcomes. See Appendix A for a summary of the outcomes from the interventional studies.

The interventions that resulted in the outcomes described above are summarized in Appendix B. The interventions included: teambuilding activities; change management; addressing incivility; recognition and rewards; time off unit for projects; assistance with barriers with projects; holding people accountable; and providing education activities.

The Curriculum for Manager Development

The *Leadership Academy for Peak Performance (LAPP)* two-day immersion course was the educational intervention for this project. The knowledge, skills and attitudes incorporated into the *LAPP* workshop as learning experiences are based on evidence in the literature of how leaders influence the work place. The *LAPP* curriculum largely captures the themes found in the literature on developing transformational leaders who influence the PPE. The evidence supporting the topics included in the *LAPP* educational program include:

Understanding how to capitalize on your strengths as a leader (Anthony et al., 2005; Cowden, Cummings & Profetto-Mcgrath, 2011; Laschinger, Finegan & Wilk, 2011; McNeese-Smith, 1995; Moneke, 2013);

Communications to build interconnected teams through trust and making decisions; (Bratt, Broome, Kelber & Lostocco, 2000; Cowden et al., 2011; Gormley, 2011; Gould, Kelly, Goldstone & Maidwell, 2001; Zori, Nosek, & Musil, 2010);

Facilitating performance within your environment (Bratt et al., 2000; Cowden et al., 2011; Fennimore & Wolf, 2011);

Balancing your energy, tools, and talents (Anthony et al., 2005; Fennimore & Wolf, 2011; Moneke, 2013);

Essentials for leaders- insight on budgeting, policy/regulatory issues, and coaching (Anthony et al., 2005; Fennimore & Wolf, 2011; Gould et al., 2001; Ulrich, Krozek, Early, Ashlock & Carman, 2010);

Transformational and innovation leadership (Chiok Foong Loke, 2001; Gould et al., 2001; Laschinger, Leiter, Day, Gilin-Oore & Mackinnon, 2012; Laschinger et al., 2011; Moneke, 2013; Cowden et al., 2011; Salanova, Lorente, Chambel & Martinez, 2011);

Emotional and social intelligence (Anthony et al., 2005; Bratt et al., 2000; Guleryuz, Guney, Aydin & Asan 2008; Smith, Profetto-McGrath & Cummings 2009);

Creating, leading and sustaining evidence-based practice environments (Melnyk, & Fineout-Overholt, 2011; Smith et al., 2009; Zori et al., 2010);

Balancing healthcare policy and regulations with patient and employee advocacy (Bratt et al., 2000; Gould et al., 2001); and

Thriving in change- employee engagement and the effects of toxic leadership (Chipps & McRury, 2012; Cowden et al., 2011; Laschinger et al., 2011; McNeese-Smith, 1995; Moneke, 2013).

Summary of Literature Review

There are a limited number of interventional studies in the literature regarding how to improve the PPE. However, there are large numbers of descriptive studies demonstrating a positive relationship between healthy PPEs and increased staff retention and satisfaction, and an inverse relationship with incivility and psychological distress. The most common intervention implemented was building staff cohesion, engagement and satisfaction by involving staff in design changes in practice and the setting. The leader communication styles and techniques, supportive and facilitative behaviors, and the collaborative posture of nursing leadership are traits important to nurse leaders as they influence the professional practice environment (Chipps & McRury, 2012; Moneke, 2013; Salanova et al., 2011; and Zori, et al., 2010.)

Chapter Three: Methods

Project Design

A pre- and post-survey design was used to evaluate the educational program *(LAPP)* on leaders' self-reported influence on the PPE. The *LAPP* was created for nursing managers/leaders as a development program for the role of influencer of the PPE. *LAPP* is an interactive two-day immersion workshop with monthly coaching sessions for one year. The *LAPP* curriculum is based on evidence, largely capturing the themes of the literature on developing transformational leaders. The project surveyed the participants for the Fall-2014 *LAPP* immersion using the valid and reliable 59-item *Leadership Influence Over Professional Practice Environments Scale* (*LIPPES*) (Adams et al., 2013) tool prior to and again two months following the program (see Appendix C). Application for Exemption as a Category #1 project was approved by the Office of Responsible Research Practices (ORRP) at The Ohio State University (See Appendix D).

Sample

The population of interest for this project was those that manage and lead nurses who attend the *LAPP* two day workshop. All participants of the *LAPP* program were eligible as long as they could read English and held a position where they could influence the PPE. The program primarily attracts Nurse Managers, Assistant Managers and those in leadership positions within departments. All of these roles influence the PPE.

Educational Program

The agenda for the two day *LAPP* workshop includes self-assessments, Triple Aim and EBP Leadership, moving from volume to value, interdisciplinary dynamics, constructing a milieu, financing for value, leadership for EBP, thriving during transformation, peer consultation and creating an executive action plan (Appendix E).

The *LAPP* workshop was held on November 17-18, 2015. There were 15 leadership competencies incorporated into the 4 modules over the 2 days.

- Communicates effectively, both verbally and in writing.
- Participative Management: Involves others, listens, and builds commitment.
- Manage Conflict: Negotiates adeptly with individuals and groups; effective at managing conflict and confrontations skillfully.
- Builds Collaborative Relationships with co-workers and external parties.
- Business Perspective: Understands the perspectives of functional areas in organization; firm grasp on external conditions affecting organization.
- Lead Change: Supports activities that position the business for the future; offers novel ideas and perspectives.
- Courage to Take Risks: Takes a stand, perseveres in face of opposition.
- Influence, Leadership, Power: Inspires a vision; motivates others; influences superiors; delegates effectively.
- Sound Judgment: Timely decisions; develops solutions that address complex issues.
- Demonstrates Vision: Communicates and stays focused on the organization's values.
- Embraces Flexibility: Thinks "out of the box" and adjusts to changes easily.
- Interpersonal Savvy: Self-aware of own impact on situations and people
- Credibility: Acts in accordance with stated values; follows through on promises; uses ethical considerations to guide decisions and actions.
- Self-Management, Self-Insight, Self-Development: Compensates for weaknesses, capitalizes on strengths; learns from experiences; self-care and aware of feelings.

- Organizational and Political Savvy: Identifies key components of organizational climate and political subculture.

In addition to the two-day immersion, the *LAPP* program includes a full year of coaching support with access to peers and experts. After the immersion program, participants stay connected via monthly webinars and coaching sessions. These webinars and coaching sessions include peers and experts who contribute insights, advice and share ideas with one another. By waiting two months before administering the post- survey, participants had an opportunity to utilize these available resources.

Methods

The investigator emailed the cover letter with an invitation to participate in this project and the electronic link to the survey to all *LAPP* workshop registrants one week before the *LAPP* workshop. The survey was conducted electronically using CHECKBOX, a software program that sends a link to the survey to participants by email. CHECKBOX has the capability to hide IP addresses to ensure anonymity of respondents. The link was sent to all registrants, but the survey responses were not linked to email addresses or individuals upon return. Additionally, the *LAPP* registrants were provided a written version of the survey at the beginning of the first day of the workshop for those wanting to participate but unable to complete the survey before arriving. This was needed due to technical difficulties with some participants working in settings out of the country.

The link to the second survey was sent to all *LAPP* registrants electronically through CHECKBOX two months following the completion of the *LAPP* workshop. No advertisement was used. *LAPP* workshop registrants were the only eligible subjects. Attrition was minimized by email reminders to all *LAPP* registrants. The demographics were only collected during the

pre-survey because both pre- and post-surveys had a code that the participants created to match their pre- and post- surveys (see Appendix F) The code was a combination of letters and numbers from the subjects' life that they would remember, yet no one else could identify (described in cover letter). The only identifier on the surveys was this code that the participant alone knew. This was included to enable comparison of individuals' pre- and post- survey data.

CHECKBOX is survey software licensed by the College of Nursing that is a secure means of collecting the data electronically. The data were stored in Dr. Bernadette Melnyk's folder on the CON R:\ drive. Storage of the data was password protected with the Co-Investigator and members of the DNP project committee as the only people with access.

The sample size was dependent upon the number of registrants; 21 participants were registered. Demographic data was collected, including role, education, years in nursing, participation in monthly coaching opportunities and a unique identifying code so that the post survey could be analyzed by comparing the post-survey data to the pre-survey data.

In lieu of a separate consent form, the participants were informed on the cover page that their participation in the project was voluntary. Completion of the survey was considered consent to participate (See Appendix G).

Timeline

This project was feasible for the six month period for fulfillment of doctoral requirements. The timeline included: receiving Institutional Review Board (IRB) approval by October 2014; *LAPP* immersion course in late November 2014 for pre-survey data collection; follow-up survey data collection in January 2015 with an opportunity for reminder emails to increase return in early February; analysis and write up occurred in February and defense in late March 2015.

Instrument

The data were collected using the *Leadership Influence over Professional Practice Environments Scale (LIPPES)* (Adams, Nikolaev, Erickson, Ditomassi & Jones, 2013) instrument, which measures the leaders' perception of the PPE that he or she manages. It is a valid and reliable instrument developed by Dr. Jeffrey Adams and team from Massachusetts General Hospital and based on the Model of the Interrelationship of Leadership, Environment and Outcomes for Nurse Executives (MILE ONE) and the Revised Professional Practice Environment (RPPE) scale (Adams et al, 2013). The *LIPPES* can be used in combination with existing staff perceptions work environment scales or internal data like staff retention, satisfaction and engagement to help nursing leadership gauge the health of the professional practice environment. This 59-item, Likert-type answer scale takes approximately 15 minutes to complete. It uses a 4 point "Never," "Sometimes," "Often," "Always," scale of choices. Permission to use the scale was obtained from the author of the instrument.

The *LIPPES* contains six subscales including collegial administrative approach (13 items), internal strategy and resolve (9 items), authority (8 items), access to resources (12 items), leadership expectations of staff (7 items) and status (10 items). Internal consistency reliability was assessed for the overall 6-factor scale with Cronbach's alpha coefficient at .968. The alpha values for each subscale were: collegial administrative approach (.937), internal strategy and resolve (.893), authority (.923), access to resources (.923), leadership expectations of staff (.913) and status (.881) (Adams et al, 2013).

As a way of characterizing the type of questions contained in the survey instrument, the operational definition of one subscale, collegial administrative approach, is "a relationship based leadership where synergy and equality are emphasized in lieu of hierarchical position" (Adams et

al, 2013, p 263). An item example for this subscale *is "You have strong supportive relationships for those reporting to you."* The status subscale is defined as "high standing or prestige identified through hierarchical position, key relationships and/or reputation" (Adams et al, 2013, p 264). *"You have a valued role in the nursing department"* is an example of an item from this subscale.

Demographics also were collected, which took participants approximately five minutes to complete. Examples of demographics included age, position, education and employment status.

Data Analysis Plan

IBM SPSS version 21 was used for data analysis. The primary question that was analyzed was whether the perception of influence changed two months after the *LAPP* educational workshop. All completed surveys were matched by the unique code to compare scores from the pre-survey to the post-survey. The data analysis began with computing descriptive statistics for each of the variables. The total average score of the pre-survey and post-survey were compared, followed by comparison of the average scores in each of the six subscales.

Since the sample size was small, concern regarding normal distribution would warrant including Wilcoxon signed rank tests. However, a paired t-test was completed because parametric analysis assumptions were met (normal distribution). As a reference point, Wilcoxon was calculated and results were consistent with the t-test results. In addition, it was planned to analyze each subscale to determine if any patterns of changes occurred to a greater extent in one subscale or another, using paired t-tests. Since we found no statistically significant differences there was no need to control for false-positive results (type I error).

Project Summary

In partial fulfillment of requirements for a Doctorate of Nursing Practice, a pre- and post-survey design was used to evaluate the impact of a two-day leadership workshop on nurse leaders' perception of their influence of the PPE. This self-reported influence on the PPE was compared before and 2 months after participation in the *LAPP* leadership program.

Chapter Four: Findings

The purpose of this DNP project was to evaluate the impact of the *LAPP* program on leaders' perceptions of their influence over the PPE two months after attending the workshop.

Participants

The total number of participants in the program was 21. Of the 21 registered participants, 19 (90%) completed the initial survey in November and 12 (57%) completed the post-survey in February, 2015. The 12 participants completing both the pre-survey and the post-survey provided a code so that their two surveys could provide matched data.

When the initial survey link was emailed, the University experienced a series of rare server failures over a 4 day period. This resulted in some participants repeatedly starting the survey and some contacting the researcher to get a "better link." During the post-survey period, 2 participants emailed the researcher with screen shots of error messages they were getting with the link. It is not known whether these attempts for the pre and post surveys were eventually successful.

The audience was atypical for this workshop because 5 participants were from Brazil with English as a second language. Three of the participants from Brazil were not nurses and one of them reported to the researcher that he did not think they were supposed to complete the survey. There were numerous incomplete surveys returned at both collection periods, but only completed surveys were analyzed.

Eleven of the 12 respondents provided demographic information. All were female. Half the participants were younger than 50 years of age and half were older than 50 years of age. Five

of the participants were immediate supervisors of the staff nurses. All participants had a graduate level degree. The distribution of their age, title and education is provided in Table 1.

Table 1 Distribution of age, title and education

	N	*%*
Age		
31-40 years	3	27.27
41-50 years	2	18.18
51-60 years	5	45.45
61 years or higher	1	9.09
Title		
Assistant Nurse Manager/Clinical Leader/Unit Educator	1	9.09
Director/Associate Chief/Associate VP/ Vice President/CNO	4	36.36
Manager/Supervisor	5	45.45
Nurse Practitioner/Clinical Nurse Specialist/Nurse Anesthetist	1	9.09
Education		
Doctoral Degree	2	18.18
Master's Degree	9	81.82

n=11

Results

For each participant, the total scores (the average of responses to all 59 items), and the subscale scores (average of their responses to the items in the given subscale) were calculated. There was no statistical difference in the total scores from the pre-survey to the post-survey. The average total score for the pre-survey was 3.35 (*sd* 0.3) and the post-survey was 3.36 (*sd* 0.3).

Table 2 provides the mean and standard deviation of the subscales and total scores.

Table 2 Total and Subscale average scores

Subscale	*Pre*		*Post*		*Difference in the*	*t Value*	*p-Value*	*Effect Size*
	Mean	*sd*	*Mean*	*sd*	*means (sd)*	*df*		*(Cohen's d)*
01	3.29	0.8	3.34	0.7	0.04 (0.16)	1 (*df* =11)	0.34	0.29
02	3.53	0.4	3.54	0.3	0.01 (0.34)	0.095 (*df* =11)	0.93	0.03
03	3.66	0.4	3.66	0.4	0 (0.43)	0 (*df* =11)	1.00	0
04	2.89	0.4	2.91	0.3	0.02 (0.35)	0.208 (*df* =11)	0.84	0.06
05	3.52	0.4	3.61	0.3	0.08 (0.32)	0.888 (*df* =11)	0.39	0.26
06	3.44	0.6	3.37	0.5	-0.08 (0.27)	-0.962 (*df* =11)	0.36	0.28
TOTAL	**3.35**	**0.3**	**3.36**	**0.3**	**0.01 (0.17)**	**1 (*df* =11)**	**0.80**	**0.07**

Paired t-tests were used to assess whether average post scores were different from average pre scores. Tests were performed for each subscale as well as for the total score. There were no statistically significant differences in the total or subscale pre and post survey scores; however effect sizes were generated because the sample size was so small and lacked power to detect significant changes. There were two subscales with small positive Effect sizes and one subscale with a small negative Effect size, they were:

Subscale 1- Collegial administrative approach (+0.29),

Subscale 5- Leadership expectations of staff (+0.26) and

Subscale 6- Status (-0.28).

Therefore, the *LAPP* workshop, as an intervention, had no statistical significance in changing the perceived influence of the participants on the PPE after two months. However, a small impact is noted with some of the subscales.

Chapter Five: Discussion and Implications

This project was an educational program impact evaluation. The DNP Essentials guided much of the work on the project. There were technological, demographic and modality limitations, that could be minimized in future applications to practice settings by recommendations described below. An ideal scenario is described for those interested in using this work to guide in a process to improve the professional practice environment in a clinical setting.

Discussion

Participants. At least half of the participants (1 = unknown) were over 51 years of age which suggests a greater amount of life and work experience. This may be some explanation for only minor changes in their perception of how they influence the PPE following the program. Looking at subscales 03, 04 and 06, the participants actually perceived their influence on the PPE as lower two months after the program. This curious result could be explained by the group starting with high confidence about their knowledge, skills and attitude as a manager before the educational program. The *LAPP* program may have raised their awareness to their own areas of weakness as a leader while identifying ways of improving.

At the two month post program point, the participants may be reporting a lower perception of their influence on the PPE because after the program they know what they need to do to raise this influence. Like Cummings and colleagues (2013) reported, changes in leader behaviors and subsequent changes in the practice environment take a long time, so evaluation too early would not capture the influence of changed leadership practices. Two month post *LAPP* program may have been too early to expect a recordable change.

Total Score. The participants reported high scores for influence on the PPE on the pre survey (3.35 out of 4) leaving little room for improvement two months later with the post survey. This "ceiling effect" occurs when higher scores are reported during surveys and obscure differences (Lammers and Badia, 2005). This is something this educator has experienced with other learning activities, especially those focused on behaviors and communication. An explanation of the "ceiling effect" is that the learner comes to the educational activity and is asked to assess themselves before the program. They record high or confident assessments of their knowledge, skills and attitudes about the given concepts. The scores are close to the ceiling for possible response, so there is little room for growth.

A plausible explanation for why scores did not improve post-workshop is that the educational activity may have enlightened them with knowledge, skills and increased self-awareness. The participant self-reports high pre- scores because *"they didn't know what they didn't know."* After the educational activity, the scores may be lower than pre activity, simply because of increased knowledge, awareness, skills and recognition of own needs for growth. Another reason for this may be that the LIPPES instrument was not sensitive enough to capture the concepts being taught in the *LAPP* program

In this project, it can be inferred that the participants recognized through the coursework how much more growth they personally needed regarding their leadership knowledge, skills and attitudes. The pre- survey confidence in their competence left little room for remarkable change over the short term of the measurement period.

Subscales. Paired t-tests of the 12 participants showed no statistically significant differences in the pre- to post- survey scores, the workshop had a small effect of three of the subscales.

Subscale 1- Collegial Administrative Approach (positive effect + 0.29), is described as relationship-based leadership where peer consultation, synergy and team approach are stressed instead of hierarchical positions. Subscale 1 items with the most movement in this project were:

- Item 53 *Effect size (0.55)*

  "You have a positive relationship with physicians working on your unit."

- Item 25 *Effect size (0.55)*

  "You have strong supportive relationships with those reporting to you."

The learning activities for the *LAPP* program involve practice on giving feedback and having difficult conversations. Perhaps this change in pre- and post- survey scores is demonstrating that participants returned to work and used those skills communicating in their work place for a successful result.

Subscale 5- Leadership Expectations of Staff (positive effect + 0.26), is described as leaders presuming that subordinates will participate in self-governance and will hold self and team accountable for practices. The items showing the greatest positive movement from pre to post surveys was:

- Item 18 *Effect size (0.33)*

  "You require staff to be responsible for their individual clinical practice."

- Item 22 *Effect size (0.23)*

  "You are understanding of the cultural differences of patients and your staff in your environment."

Many managers express frustration with subordinates complaining, "telling on others" and avoiding involvement in work place decisions preferring to blame others for the situation.

This *LAPP* program explored the future of healthcare; the need to inspire vision, motivate others and maneuver the organizational climate; as well as, adoption of a participative management style that embraces flexibility. The workshop combination of: 1) new knowledge; 2) practice applying it to scenarios; and 3) self-reflection exercises to recognize areas where to personally change; could have led to movement with these items on the influence scale two months later.

Subscale 6- Status (negative effect -0.28) is defined as being highly respected and being held in high esteem through position or reputation. Curiously, 5 of the items in this scale were reported as less on the post survey, than the pre survey. These items portray how a person feels their prestige stands in the workplace. Examples include:

- Item 27 *Effect size (0.55)* negative effect

  "You have a positive reputation with peers in your organization."

- Item 30 *Effect size (0.51)* negative effect

  "You have sufficient status within your organization's hierarchy to influence the practice environment."

It is possible that the discussions of global healthcare initiatives and the means to make these a reality caused these participants to realize that they were not making the impact on the organization like they could or should. Raising their awareness to how much more effective they could be may have made them reassess their current standing and realize they didn't have the influence and impact that they thought they had prior to attending the workshop.

Summary of Discussion

The highlights of the results and discussion include:

- The "ceiling effect" was present on the pre-survey as participants started with high confidence about their knowledge, skills and attitude before the program.

There was not much room for improvement in their scores. The program may raise awareness to own areas of weakness as a leader while identifying ways of improving.

- Participants returned to their work settings and used feedback and difficult conversations skills to communicate more effectively.
- The participant's expectations of staff changed after exploring the future of healthcare; the need to inspire vision, how to motivate others and maneuver the organizational climate; as well as, adoption of a participative management style and embracing flexibility.
- The course raised awareness of how to be more effective. Participants reassessed their current standing determining they were not making the impact on the organization like they could or should.

Implications for Nursing Practice and to the DNP Essentials

The implications for advanced nursing practice relative to these Doctorate of Nursing Practice (DNP) project findings as it relates to the DNP Essentials are described below. This DNP project specifically addressed the first six of the eight DNP essentials. The six essentials in the DNP education (American Association of Colleges of Nursing [AACN], 2006) include:

I. Nursing Science and Theory: Scientific Underpinnings for Practice
II. Systems Thinking, Healthcare Organizations, and the Advanced Practice Nurse Leader
III. Clinical Scholarship and Evidence-Based Practice
IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
V. Healthcare Policy for Advocacy in Health Care
VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Essential I: The traditional medical model approach to fixing problems is to decontextualize pieces of data and test for best intervention to improve outcome. In contrast, nurses use a human based approach considering issues holistically, expanding the view to see the context, considering feelings, and raising up the significance of relationships (Zaccagnini and White, 2011). Using nursing theory and science to approach the challenge of facilitating a positive professional practice environment by focusing on participative and transformational leadership styles is radically different form the hierarchical-transactional approach to leadership. Historically, hierarchical-transactional leadership is associated with the decontextualized management of both military and medical models, which are the primary influences on the current healthcare infrastructure.

In the pursuit of positive PPEs, inspiration, self-reflection, communication skills practice and motivating both the leaders and the professionals will be essential. This project, though small in scope, focused on the difficult task of using a nursing holistic-expansive approach to fix a problem in an environment built by hierarchical-transactional leadership.

Essential II: Healthcare organizations have been charged with the Triple Aim of improving outcomes and patient experience while reducing the cost of healthcare. This requires that we work in learning organizations that:

Continually develop the workforce (return to school, certifications, continuing education, inservices, conference participation);

Encourage questioning and clinical inquiry (provide means to purse projects);

Support the process of change, including opportunity for reflection, creative thinking, learning from past, resources to plan and implement changes;

Recognize the efforts and passion for the work (informal and formal feedback); and

Provide venues to disseminate best practices internally and externally, to speed the rate of healthcare improvements.

This project is focused on using organizational knowledge and systems thinking to figure out how to efficiently create learning organizations. The positive professional practice environment is the core of the future success of healthcare organizations.

Essential III: The seven-step evidence-based practice process starts with clinical inquiry, asking questions about a problem. This project started with the discussion of what negative professional practice environments lead to:

Ineffective collaboration due to intimidating behavior;

Dangerous communication patterns;

Low employee satisfaction;

Low patient satisfaction;

Increased safety issues;

Greater number of preventable errors;

Increased incivility (or lateral violence) with coworkers; and

Inflexible clinical practice based on "we have always done it that way."

The PICO question and search of the literature determined that the work environment needs to be supportive physically, emotionally, intellectually, and spiritually in order to recruit and retain the caregivers. With an engaged workforce, the quality of care and patient experience will improve as the cost of care is reduced. The evidence in the literature pointed to the single largest influence on the PPE as the manager with communication styles, supportive and facilitative behaviors and a collaborative posture as traits important to developing a positive professional practice environment.

Since managers and those in nursing leadership roles are pivotal in their influence of the PPE, this project focused on how to develop the knowledge, skills and attitudes needed by nursing leaders to facilitate positive professional practice environments. The project implementation was measuring the Leaders Influence over the Professional Practice Environment before and 2 months after a nationally recognized leadership development course. The last step of the process is to disseminate the lessons learned from this project internally (Defense, March 25, 2015) and externally (at the International Sigma Theta Tau Research and EBP conference in July 2015).

Essential IV: In this project, technology was used to build and distribute the survey and analyze the data. The Checkbox software is more complicated to use than freely available software such as Survey Monkey. This learning curve and the inevitable challenges like server malfunctions and troubleshooting error messages for participants contributed to a substantial increase in this researcher's comfort level with these forms of technology from beginning to end of the project.

Essential V: Healthcare policy for advocacy in health care was part of the curriculum for the *LAPP* program. Leaders need to understand the macro system including the national, political and even global factors affecting health to best create the vision and inspire those in the professional practice environment. This was an enlightening topic area for most of the participants who generally focus at the microsystem level of the unit, versus the larger macrosystem context in which the unit interacts. The LAPP program emphasizes the need for nurse leaders to consider the macrosystem in their pursuit of a positive PPE.

Essential VI: The leadership in clinical areas is not restricted to nurses, nor is the team that nurse managers lead, exclusively nurses. This project collaboration with a variety of

disciplines was experienced on 3 levels: 1) the participants were from multiple disciplines; 2) the faculty of the *LAPP* program was multidisciplinary; and 3) the author collaborated with multiple disciplines to successfully complete the project. Clearly, the Essential for interprofessional collaboration is vital for the role of a Doctorate of Nursing Practice.

Limitations

Technological limitations. Though the CHECKBOX application was able to anonymize the data and distribute the survey to participants internationally, the worksite "firewalls" of many of the participants blocked the link. This resulted in frustration for some of the participants, and some of them making the effort to send different email addresses that would not block the link. Sending the electronic surveys using CHECKBOX through the University servers also proved to jeopardize the success of the data collection because the servers happened to have a rare 4 day intermittent problem just as the link was sent to participants.

Could these technology frustrations have affected the participant's willingness to complete the survey? Could the frustrations have affected the participant's thoughtfulness or carefulness in answering the questions?

Small sample size. The project had a small number of participants, gender (all female), education background (all graduate level degrees) and the majority of the participants were greater than 51 years of age. The group lacked heterogeneity related to gender, education and age and who could benefit from this educational experience, however as an evidence-based practice project, generalizability is not an expectation.

Modality limitations. Ideally, a group of leaders from one setting, preferably from a group of units or clinical areas who interact with each other daily, would participate in the *LAPP* program together. Use of the common educational experience, terminology, skills developed

and communication techniques to support each other could result in larger changes to the culture of a work environment. In this way, the outcomes of staff retention, preventable errors, employee satisfaction and patient satisfaction could be measured and perhaps the increasing influence of the managers on the PPE would be realized. A project such as this would take at least 18 months to measure impact and would benefit from adding a self-reported measure of the professional practice environment from all roles in the environment prior to and following the leader participation in the *LAPP* program.

Implications

Recommendations. Recommendations for further application to the practice environment would include:

- Repeat the *LIPPES* in 18 months post educational program completion. This would provide enough time for the intervention to be applied to the manager behaviors and the impact of the coaching sessions to make a change in their perception of influence.
- The suggested metrics would be to track the employee satisfaction, retention, patient satisfaction, preventable errors, and employee engagement measures.
- Addition of the Revised Professional Practice Environment (RPPE) scale to provide leaders with feedback on the perception of the PPE from the perspective of all disciplines involved in the clinical area.
- Consider other instruments that will evaluate the impact of the *LAPP* program.
- Concentrate the efforts to improve the PPE by having leaders in one division or service line that works closely together focus on culture changes at the same time.

Ideal Scenario for the Future. An ideal scenario would include improvement in the PPE of a division or service line in an organization. Include all areas that work closely on a daily

bases in the same initiative. Before intervening with the *LAPP* program to develop the leaders, survey all multidisciplinary staff using the RPPE in addition to the quality metrics mentioned above. The leadership would also complete the *LIPPES* whether or not they were able to participate in the *LAPP* program.

Following collection of these baseline measures (RPPE, metrics and *LIPPES*) scheduling a large percentage of the Leadership team to participate in the *LAPP* program over a short period of time, would be the primary intervention. Using the knowledge, skills and attitude changes from the *LAPP* program, along with the data from the RPPE, metrics and *LIPPES,* the leadership team would set about making changes to improve the PPE. Because moving a culture takes time, data would be collected a year after the leaders complete the LAPP program and participate in the coaching sessions and compared to the baseline. This would provide a clearer picture of what areas improved and what still needed improvement.

For example, if Peri-Operative Services decided to work on this, they would survey staff from Pre Admission Testing, Surgery Unit, Procedural Unit, Operating Room, Post Anesthesia Care Unit, Anesthesia and Support Services to gather a baseline of their perception of the PPE. At the same time, they would survey all the Clinical Managers, Assistant Managers, Directors, Vice Presidents and other clinical leadership in the setting to capture their *LIPPES* scores. Next, they schedule at least 50% of their leadership staff to participate in the *LAPP* program. Using the baseline data and the *LAPP* program knowledge, skills and attitudes the leadership team would design multiple interventions to improve the PPE. After 12-18 months of implementing changes, the RPPE, metrics and *LIPPES* would be collected for comparison to the baseline. By using a division, instead of managers from all over an organization, more concentrated effort with a standardized intervention should achieve greater impact on the PPE.

Summary

This project was an educational program impact evaluation. The sample was drawn from the participants of the Fall-2014 *Leadership Academy for Peak Performance* (*LAPP*). The *Leadership Influence over Professional Practice Environments Scale* (*LIPPES*) (Adams, Nikolaev, Erickson, Ditomassi & Jones, 2013) was administered before the course began. Then, two months after the course completion, the survey was re-administered. Although there were no statistically significant results from the analysis of the pre survey and post survey data, small effect sizes in three of the six subscales of the *LIPPES* suggests: 1) the participant's expectations of staff changed after exploring the future of healthcare, organizational climate and participative management styles; and 2) the course raised awareness of how to make a greater impact on the organization. Therefore, the *LAPP* program contributes to developing nursing and healthcare leadership so that they can provide a positive influence on the professional practice environment.

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Appendix A

Summary of Outcomes from Interventional Studies

Outcomes	1	2	3	4	5	6	7	8	9	10	11	12
Nurse retention		Inc	Inc					Inc				
Vacancy rate								Dec			NC	
Patient satisfaction							Inc	Inc			Inc	
Nurse satisfaction; happiness at work	Inc	Inc		Inc	Inc		Inc	Inc	Inc	Inc		Inc
Decubitus ulcer rate								Dec				
Turnover		Dec			Dec	Dec		Dec			Inc*	Dec
Level of work engagement- involved in organizational and clinical decision making	Inc	Inc	Inc						Inc			NC
Vigor-energy, fatigue, resilience, persistence, effort, "best self";	Inc		Inc							Inc		Inc
Intent to stay; organizational commitment;									Inc	Inc		
Return to School		Inc										
Self-report by leaders of applying leadership concepts				Inc		Inc						
Work Group cohesion	Inc		Inc		Inc							
Group Dynamics and Functioning					Inc							
Empowerment									Inc			
Supervisor /Coworker incivility	Dec		Dec		Dec			Dec	Dec	Dec	Dec	Dec
Trust in management				Inc		Inc	Inc		Inc	Inc		Inc
Absenteeism										Dec		
Staff stress levels; emotional exhaustion	Dec									Dec		Dec

Inc = increased; Dec = decreased; NC = no change blank = not evaluated

*Turnover decreased for years 1-3 and increased on year 4. Reported variation between 30 hospitals studied'

1) Bishop (2013); 2) Brunges & Foley-Brinza (2014); 3) Calarco (2011); 4) Cummings et al. (2013); 5) DiMeglio et al., (2005); 6) Fennimore & Wolf (2011); 7) Hall, Doran & Pink (2008); 8) Kooker & Kamikawa (2010); 9) Laschinger, et al. (2012); 10) Leiter, et al. (2011); 11) Meraviglia, et al, (2009); 12) Rickard et al.(2012)

Appendix B

Summary of Interventions from Interventional Studies

Interventions	1	2	3	4	5	6	7	8	9	10	11	12
Staff interventions supported by leaders	X	X	X		X		X	X	X	X		
Positive Organizational Scholarship or learned optimism (5 year)			X									
Teambuilding- group cohesion and job enjoyment; organizing fun events	X	X	X		X	X	X	X	X	X		
Change management				X	X	X	X	X		X		
CREW process (Civility, Respect, Engagement in the Workplace)									X	X		
Address incivility		X	X			X			X	X	X	
Recognition and reward	X	X							X		X	
Time off unit for projects	X	X	X				X		X	X		
Assist with challenges/ barriers		X	X			X	X		X	X		X
Being held accountable		X			X	X		X		X	X	X
Safeguarding breaks	X	X										
Making a serenity room		X										
Creating the patient ambassador role		X									X	
Redesigning the unit		X						X				
Lessening stress- adjusting schedules		X										X
Providing education activities	X	X	X	X	X	X		X	X	X	X	X
Supporting Unit Practice Council		X			X		X				X	
Communication and collaboration		X	X	X	X	X	X	X	X	X	X	X
Unit level performance improvement projects								X			X	
Huddles at beginning of shift									X			
Nurse Friendly Hospital Criteria- work to gain											X	
Used Nursing Workload Tool- results: 1. Added nursing positions 2. Nurse recruitment strategy 3. Expanded new graduate program 4. Increased access to professional development activities												X

1) Bishop (2013); 2) Brunges and Foley-Brinza (2014); 3) Calarco (2011); 4) Cummings et al. (2013); 5) DiMeglio et al., (2005); 6) Fennimore & Wolf (2011); 7) Hall, Doran & Pink (2008); 8) Kooker & Kamikawa (2010); 9) Laschinger, et al. (2012); 10) Leiter, et al. (2011); 11) Meraviglia, et al, (2009); 12) Rickard et al.(2012)

Appendix C

Leadership Influence over Professional Practice Environment Scale

Mother's maiden name initials __ __ __; Two digit day of your birthday __ __; Last two digits of home phone __ __
1 2 3 4 5 6 7

Your Unique identifier code: ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

		Never	Sometimes	Often	Always
1	You have the right to take actions related to making changes of the practice environment on your unit(s)?				
2	You have access and adequately procure *financial support* to maximize the practice environment on your unit(s)?				
3	You have access and adequately procure *physical resource* support to maximize the practice environment on your unit(s)?				
4	You have access and adequately procure *staffing (human) resource support* to maximize the practice environment on your unit(s)?				
5	You have access and adequately procure *informational support* to maximize the practice environment on your unit(s)?				
6	You have responsibility for the practice environment on your unit(s)?				
7	You are answerable *to superiors* regarding the practice environment on your unit(s)?				
8	You are answerable *to peers* regarding the practice environment on your unit(s)?				
9	You are answerable *to direct reports* related to the practice environment on your unit(s)?				
10	You are accountable for your unit(s)' practice environment?				
11	It is your obligation to maximize the practice environment of your unit(s)?				
12	You are accountable *to superiors* related to the quality of the practice environment on your unit(s)?				
13	You are accountable *to peers* related to the quality of the practice environment on your unit(s)?				
14	You are accountable *to direct reports* related to the quality of the practice environment on your unit(s)?				
15	You are autonomous in your decision making related to the practice environment on your units(s)?				
16	You have control over your administrative practice as it related to the practice environment on your unit(s)?				
17	You have control over the clinical practice on your unit(s)?				

Appendix C (con't)

18	You require staff to be responsible for their individual clinical practice?				
19	You have sufficient administrative assistant support?				
20	You are creative in finding ways to maximize the practice environment on your unit?				
21	You are visionary in your approach to maximize the practice environment?				
22	You are understanding of the cultural differences of patients and your staff in your practice environment?				
23	You have supportive relationships *with superiors* in your organization?				
24	You have strong supportive relationships *with peers* in your organization?				
25	You have strong supportive relationships *with those reporting* to you?				
26	You have a positive reputation *with superiors*?				
27	You have a positive reputation *with peers* in your organization?				
28	You have a positive reputation *with those reporting to you*?				
29	You have a positive reputation *in your organization*?				
30	You have sufficient status within your organization's hierarchy to influence the practice environment?				
31	You have a distinct role in the organization?				
32	You have a valued role in the nursing department?				
33	You have scheduled group meetings with direct reports to discuss the professional practice environment on your unit(s) ?				
34	You have scheduled individual meetings with direct reports to discuss the professional practice environment on your unit?				
35	You usually have enough time to complete projects that enhance the practice environment of your unit?				
36	You have time in your workday to work to improve the professional practice environment?				
37	You plan change(s) that will impact the professional practice environment in advance?				
38	You require staff to be responsible for each other's practice on your unit(s)?				
39	You hold staff accountable for their individual clinical practice?				
40	You hold staff accountable to address colleagues directly when there is a question about a colleague's clinical practice?				

Appendix C (con't)

41	You hold staff accountable to notify leadership when there is a question about a colleague's clinical practice?				
42	You confidently communicate *with superiors* regarding the practice environment on your unit(s)?				
43	You confidently communicate *with peers* regarding the practice environment on your unit(s)?				
44	You confidently communicate *with direct reports* regarding the practice environment on your unit(s)?				
45	You are engaged in improving the professional practice environment?				
46	You are committed to improving the professional practice environment?				
47	You have internal motivation to do your job?				
48	You are persistent in your attempts to improve the professional practice environment?				
49	You are confident in your ability to improve the professional practice environment?				
50	You have a strong presence on your unit?				
51	You have a strong presence within the organization?				
52	You present yourself in a professional manner?				
53	You have a positive relationship with physicians working on your unit?				
54	You address conflicts between direct reports and yourself with a defined resolution for both parties?				
55	You address conflicts between 2 members of your staff or a member of your staff and someone not reporting to you with a defined resolution for both parties?				
56	You are flexible with regard to work schedules of those reporting to you?				
57	You are influential related to your unit(s) practice environment?				
58	You are influential with superiors related to your unit(s) practice environment?				
59	You are influential with those reporting to you related to your unit(s) practice environment?				

Appendix D

IRB Application for Exemption

Office of Research
Office of Responsible Research Practices

Protocol Title:	Manager's Influence on the Work Environment
Protocol Number:	2014E0408
Principal Investigator:	Bernadette Melnyk
Date of Determination:	09/29/2014
Qualifying Category:	2
Attachments:	None

Dear Investigators,

The Office of Responsible Research Practices has determined the above referenced project **exempt from IRB review**.

Please note the following:

- Retain a copy of this correspondence for your records.
- Only the OSU staff and students named on the application are approved as OSU investigators and/or key personnel for this study.
- No changes may be made to exempt research (e.g., personnel, recruitment procedures, advertisements, instruments, etc.). If changes are need, a new application for exemption must be submitted for review and approval prior to implementing the changes.
- Per university requirements, all research-related records (e.g., application materials, letters of support, signed consent forms, etc.) must be retained and available for audit for a period of at least three years after the research has ended.
- It is the responsibility of the investigators to promptly report events that may represent unanticipated problems involving risks to subjects or others.

This determination is issued under The Ohio State University's OHRP Federalwide Assurance #00006378. All forms and procedures can be found on the ORRP website: www.orrp.osu.edu.

Please feel free to contact the Office of Responsible Research Practices with any questions or concerns.
Thank You,
Ellen

Ellen Patricia, MS, CIP
Program Director
HRPP Quality Improvement
Office of Research Office of Responsible Research Practices
307 Research Administration Building , 1960 Kenny Road, Columbus, OH 43210
614-688-5556 Office / 614-688-0366 Fax
patricia.1@osu.edu www.orrp.osu.edu

Appendix E

Leadership Academy for Peak Performance
LAPP
An initiative of The Ohio State University College of Nursing

ANA
AMERICAN NURSES ASSOCIATION
LEADERSHIP INSTITUTE

Day 1: November 17, 2014

MODULE 1: Self Leadership: Personalizing the Triple Aim In the Executive Role
(Competencies 1, 7, 8, 9, 10, 11, 13, 14)

8:00-8:10	Welcome	Scott Graham
8:10-8:40	Leadership Practices Inventory: Assessing Service, Quality, Cost Leadership	Scott Graham
8:40-9:15	Advanced Role and Emotional Competence for Innovation Leadership	Scott Graham
9:15-9:30	Recovery Break	
9:30-10:00	Strength Determination for Leadership of Triple Aim Innovations	Scott Graham
10:00-10:30	Coaching Mentoring Styles	Scott Graham
10:30-11:30	Peer Consultation #1	Scott Graham
11:30-12:30	Lunch	

MODULE 2: Executive Team Leadership
(Competencies 1,2,3,4,7,8,9,10,11,12, 13)

12:30-1:30	Executive Life Calibration: Negotiating the C-suite in the Balance of Life	Lynn Gallagher-Ford
1:30-2:00	The Role of Executive Vision: Building an Environment for Triple Aim	Lynn Gallagher-Ford
2:00-2:40	Advancing and Implementing the Triple Aim: Leadership in EBP	Lynn Gallagher-Ford
2:40-2:55	Recovery Break	
2:55-3:25	From Volume to Value: Creating Context for Triple Aim Transformation	Jerry Mansfield
3:25-3:55	Building the Transdisciplinary Framework for Value-driven Health Service	Jerry Mansfield
3:55-4:25	Setting an Even Table: Interdisciplinary Team Dynamics and Management	Jerry Mansfield
4:25-4:55	Constructing the Milieu for Team Engagement of the Triple Aim	Scott Graham
4:55-5:00	Evaluation and Look Ahead to Day 2	Scott Graham
5:00-7:00	Event Reception and Executive Networking (in the Atrium)	

Day 2: November 18, 2014

MODULE 3: Transforming the Organization for the Triple Aim
(Competencies 1,2,3,4,5,6,7,8,9,10,11,12, 13)

8:00-8:45	Financing for Value: Resourcing the Triple Aim	Jerry Mansfield
8:45-9:45	Innovation of Practice: Implementing Triple Aim Objectives	Tim Porter-O'Grady
9:45-10:00	Innovation and the Executive	Tim Porter-O'Grady
10:00-10:15	Recovery Break	
10:15-11:00	Change for Value and Thriving during Transformation	Scott Graham
11:00-12:00	Peer Consultation #2	Scott Graham
12:00-1:00	Lunch	

MODULE 4: Creating Partnerships in the Community
(Competencies 1,2,3,4,5,6,7,8,9,10, 11, 12, 13)

1:00-2:00	The Future of Health Care-Transformation & Innovation Leadership	Tim Porter-O'Grady
2:00-2:30	Executive Drivers for Sustainable Engagement of Value in Triple Aim Journey	Tim Porter-O'Grady
2:30-2:45	Recovery Break	
2:45-3:45	Healthcare Policy & Regulations: Creating Value, Why You Should Care?	Margaret Graham
3:45-4:45	Peer Consultation #3	Scott Graham
4:45-4:55	Creating an Executive Action Plan: Your Journey-Putting it Together	Scott Graham
4:55-5:00	Evaluation and Graduation	Scott Graham

Appendix F

Instrument B: Demographics, Personal Professional and Organizational Background

1. Your primary title is best described as
   - Charge Nurse / Staff Nurse
   - Assistant Nurse Manager / Clinical Leader / Educator
   - Allied Health Team member / Respiratory Therapy/ Child Life
   - Manager / Supervisor
   - Nurse Practitioner / Clinical Nurse Specialist / Nurse Anesthetist
   - Director / Associate Chief/ Associate VP / Vice President/ CNO

2. Indicate the highest level of education
   - .. Associates Degree
   - .. Baccalaureate Degree
   - .. Master's Degree
   - .. Doctoral Degree

3. If you are currently enrolled and have started in a degree granting program, please list that program
   - .. Baccalaureate Degree
   - .. Master's Degree
   - .. Doctoral Degree

4. Please list any professional administrative accreditations or credentials you maintain
   - .. NE-BC
   - .. NEA-BC
   - .. FACHE
   - .. Other

5. Your Age
   - 20-30 years
   - 31-40 years
   - 41-50 years
   - 51 -60 years
   - 61 on up

6. Your Gender
   - .. Male
   - .. Female

7. Employment status
   - .. Full time (37 or more hours per week)
   - .. Part time (20-36 hours per week)
   - .. Temporary/ Per diem or < 20 per week

BEFORE Survey

8. I anticipate I will participate in/access the following resources after the workshop (Choose all that apply)
   - One-to-one coaching with *LAPP* faculty
   - Live monthly webinars (OR listen to a recording of a webinar)
   - Maintain contact with other participants;
   - Website resources

AFTER Survey

8. Since the *LAPP* program, I have participated in the following (choose all that apply):
   - One-to-one coaching with *LAPP* faculty
   - Live monthly webinars (OR listen to a recording of a webinar)
   - Maintain contact with other participants;
   - Website resources

Appendix G

(Assent Form)

Professional Practice Environment

Survey Instructions

Hello,

I am a Doctoral student completing a project for my course requirements.

I am asking you to complete this survey before you begin the Leadership Academy for Peak Performance (*LAPP*) workshop and then repeat this same survey approximately 2 months from today.

You are being asked to participate in this study because you are enrolled in the *LAPP* workshop to be held on Nov 17 and 18, 2014. The purpose of this project is to measure nursing leadership perceive influence on the professional practice environment before and two months after participation in the *LAPP* workshop.

The survey will take approximately 15 minutes to complete. I will assume you consent by your completion of the survey. It is voluntary to complete, you may skip any questions you feel uncomfortable answering and you may withdraw at any time without penalty or loss of benefits.

To maintain your confidentiality I am asking you to code your survey in a way that only you will be able to identify it, but will enable me to match your first survey and the survey you complete two-months later for analysis. Use the following code:

What are your **mother's maiden name initials**? ___ ___ ___
(first name, middle name, last name)
Use an X for the middle initial if your mother does not have a middle name.
(for example Jennifer Suzanne Maxton = J S M or Leighmae Wang = L X W)

What is the two digit day of **your** birthday? ___ ___
for example July 14th = 1 4;
December 3rd = 0 3

What are the last two digits of your home phone number
(or your cell phone, if you do not have a home phone) ___ ___

I will be able to remind you of this code on the second survey, so neither of us will need to record it.

Thank-you, so much, for participating in this study, your efforts will contribute to the growing knowledge of the influences on the Professional Practice Environment.

Cathleen Opperman RN, MS, NEA-BC, CPN

Contacts and Questions:

Principal Investigator for questions, concerns, or complaints about the study:
Dr. Bernadette Melnyk PhD, RN
Dean, Associate Vice President for Health Promotion, Chief Wellness Officer
melnyk.15@osu.edu
phone: 614-292-8900

Key Personnel:
Cathleen S Opperman RN, MS, NEA-BC, CPN
Professional Development Nurse Specialist
Opperman.33@osu.edu
Phone: 614-388-0738

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

Appendix G (con't)

(Assent Form)

Professional Practice Environment

2 Month Post Course Survey Instructions

Hello,

I am a Doctoral student completing a project for my course requirements.

I am asking you to complete this survey approximately 2 months after the Leadership Academy for Peak Performance (*LAPP*) workshop, as described in November. This survey is being sent to all registered for the November 17 and 18, 2014 *LAPP* workshop by email.

You are being asked to participate in this study because you were enrolled in the *LAPP* workshop. The purpose of this project is to measure nursing leadership perceive influence on the professional practice environment before and two months after participation in the *LAPP* workshop.

The survey will take approximately 15 minutes to complete. I will assume you consent by your completion of the survey. It is voluntary to complete, you may skip any questions you feel uncomfortable answering and you may withdraw at any time without penalty or loss of benefits.

To maintain your confidentiality I asked you to code your survey in a way that only you would be able to identify it, but will enable me to match your first survey and this second survey for analysis. Use the following code:

What are your **mother's maiden name initials**? ___ ___ ___
(first name, middle name, last name)
Use an X for the middle initial if your mother does not have a middle name.
(for example Jennifer Suzanne Maxton = J S M or Leighmae Wang = L X W)

What is the two digit day of **your** birthday? ___ ___
for example July 14th = 1 4;
December 3rd = 0 3

What are the last two digits of your home phone number ___ ___
(or cell phone, if you do not have a home phone)

I was able to remind you of this code on this second survey, so neither of us needed to record it.

Thank-you, so much, for participating in this study, your efforts will contribute to the growing knowledge of the influences on the Professional Practice Environment.

Cathleen Opperman RN, MS, NEA-BC, CPN

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